

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0033761</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Rose-Angela Hall</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/02</u> to <u>06/30/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>4200 N. Austin Avenue</u> <u>Chicago, IL</u> <u>60634</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Sr. Rita Butler</u> (Title) _____	
Telephone Number: <u>773-545-8300</u> Fax # <u>773-545-2984</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()	
IDPA ID Number: <u>36-2171748001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>08/19/88</u>			
Type of Ownership:			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust			
IRS Exemption Code <u>501 c 3</u>			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____			
<input type="checkbox"/> GOVERNMENTAL			
<input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Beverly Sorensen</u> Telephone Number: <u>773-545-8300 X311</u>			

Facility Name & ID Number Rose-Angela Hall# 0033761 Report Period Beginning: 07/01/02 Ending: 06/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>80</u>	Intermediate/DD	<u>80</u>	<u>29,200</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>80</u>	TOTALS	<u>80</u>	<u>29,200</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>25,980</u>			<u>25,980</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,980</u>			<u>25,980</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 88.97%

D. How many bed-hold days during this year were paid by Public Aid?

2,603 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)none

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 09/13/88

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/03 Fiscal Year: 06/30/03

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Rose-Angela Hall

0033761

Report Period Beginning: 07/01/02

Ending: 06/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	149,768	7,592	22,345	179,705		179,705		179,705			1
2	Food Purchase		78,295		78,295		78,295		78,295			2
3	Housekeeping	56,232	15,439		71,671		71,671		71,671			3
4	Laundry	15,354	4,982		20,336		20,336		20,336			4
5	Heat and Other Utilities			82,706	82,706		82,706		82,706			5
6	Maintenance	88,291	60,149	69,444	217,884		217,884		217,884			6
7	Other (specify):*											7
8	TOTAL General Services	309,645	166,457	174,495	650,597		650,597		650,597			8
	B. Health Care and Programs											
9	Medical Director	25,631			25,631		25,631		25,631			9
10	Nursing and Medical Records	1,630,437	28,161	8,773	1,667,371		1,667,371		1,667,371			10
10a	Therapy			36,993	36,993		36,993		36,993			10a
11	Activities	52,123			52,123		52,123		52,123			11
12	Social Services	5,974			5,974		5,974		5,974			12
13	Nurse Aide Training	7,742	430		8,172		8,172		8,172			13
14	Program Transportation		10,838		10,838		10,838		10,838			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,721,907	39,429	45,766	1,807,102		1,807,102		1,807,102			16
	C. General Administration											
17	Administrative	99,654			99,654		99,654		99,654			17
18	Directors Fees											18
19	Professional Services			36,783	36,783		36,783		36,783			19
20	Dues, Fees, Subscriptions & Promotions			6,187	6,187		6,187		6,187			20
21	Clerical & General Office Expenses	138,757	55,990	15,052	209,799		209,799		209,799			21
22	Employee Benefits & Payroll Taxes			348,585	348,585		348,585		348,585			22
23	Inservice Training & Education			744	744		744		744			23
24	Travel and Seminar			1,724	1,724		1,724		1,724			24
25	Other Admin. Staff Transportation		1,913		1,913		1,913		1,913			25
26	Insurance-Prop.Liab.Malpractice			44,427	44,427		44,427		44,427			26
27	Other (specify):*											27
28	TOTAL General Administration	238,411	57,903	453,502	749,816		749,816		749,816			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,269,963	263,789	673,763	3,207,515		3,207,515		3,207,515			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rose-Angela Hall

#0033761

Report Period Beginning:

07/01/02

Ending:

06/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			198,572	198,572		198,572	(3,380)	195,192			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			198,572	198,572		198,572	(3,380)	195,192			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			209,521	209,521		209,521		209,521			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			209,521	209,521		209,521		209,521			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,269,963	263,789	1,081,856	3,615,608		3,615,608	(3,380)	3,612,228			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Rose-Angela Hall# 0033761

Report Period Beginning:

07/01/02

Ending:

06/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(3,380)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (3,380)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,380)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Rose-Angela Hall

ID# 0033761

Report Period Beginning: 07/01/02

Ending: 06/30/03

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

06/30/03

06/30/03

[illegible]

Summary B

06/30/03

06/30/03

[illegible]

Facility Name & ID Number Rose-Angela Hall# 0033761

Report Period Beginning:

07/01/02

Ending:

06/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Daughters of St. Mary of Providence	100			St. Mary of Providence	Chicago, IL.	Day Programs Operating Corp.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	Rent Facility/ Bldg, Grounds	\$ 66,000	Daughtgers of St. Mary of Providence	100.00%	\$ 62,620	\$ (3,380)	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 66,000			\$ 62,620	\$ * (3,380)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Daughters of St. Mary of Providence
 Street Address 4200 N. Austin Ave
 City / State / Zip Code Chicago, IL. 60634
 Phone Number (773-545-8300
 Fax Number (773-545-2984

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Rose-Angela Hall**# **0033761** Report Period Beginning: **07/01/02** Ending: **06/30/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998	8	
	1999	9	
	2000	10	
	2001	11	
	2002	12	
			FOR OHF USE ONLY
			13 FROM R. E. TAX STATEMENT FOR 2002 \$ 13
			14 PLUS APPEAL COST FROM LINE 5 \$ 14
			15 LESS REFUND FROM LINE 6 \$ 15
			16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rose-Angela Hall COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033761

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A.

Square Feet:

51,510

B.

General Construction Type:

Exterior

Brick

Frame

Number of Stories

C.

Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

St, Mary of Providence School

34671 sq ft 62 day units

Providence Center - Community Living Facility

13647 Sq. Ft. 16 beds

Rose Angela Hall - Day Training Facility

25851 sq. ft. 110 day units

Providence Center-Adult Work Acitivity Ctr.(now part of DT)

6653 sq. ft. 110 day units

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Residential	66,437	1925	\$ 50,975	1
2	Improvements		Various	24,500	2
3	TOTALS	66,437		\$ 75,475	3

Facility Name & ID Number Rose-Angela Hall

0033761

Report Period Beginning:

07/01/02

Ending:

06/30/03

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		1979	1980	\$ 2,031,195	\$ 17,314	30	\$ 17,314		\$ 1,815,986	4
5	Laundry		1938	1938	73,366		60			73,366	5
6	Kitchen		1956	1956	259,122		25			259,122	6
7	Office		1928	1928	104,867		45			104,867	7
8	Office		1953	1953	71,484		45			71,484	8
	Improvement Type**										
9	Remodling			1978	72,153		25			72,153	9
10	Painting, Drywall			1980	13,098		20			13,098	10
11	Repairs			1980	24,301	243	20	243		23,319	11
12	Roof/tucking			1988	8,466	423	20	423		6,309	12
13	Repairs, Painting Decorating			1988	41,231		10			41,231	13
14	Decorating			1990	3,836	170	10	170		3,449	14
15	Asphalt Paving Lot			1990	16,650	1,110	15	1,110		15,540	15
16	Garage, Disposal			1990	24,862	995	25	995		13,927	16
17	Remodling			1991	45,685	2,284	20	2,284		26,719	17
18	New Boiler-Kitchen Bldg			1998	12,320	821	15	821		4,926	18
19	New Boiler Adm Bldg.			1998	5,320	355	15	355		2,130	19
20	Install Handicap ramp/remodel front entrance			2001	140,185	7,010	20	7,010		17,525	20
21	Remove & install new fence around perimeter&electronic gates			2001	106,000	5,300	20	5,300		13,250	21
22	Addl re electronic gates & fence			2002	19,421	971	20	971		1,942	22
23	New rooftop HVAC units to replace existing			2002	248,000	16,533	15	16,533		23,799	23
24	Addl re ramp & fence ICF			2003	103,055	2,576	15	2,576		2,576	24
25	Carpentry, Shelving, elec. Gate			1988	44,779	336	15	336		44,509	25
26	Outdoor rec area			1989	12,400	827	15	827		11,163	26
27	g hall windows ac			1990	24,239	1,212	20	1,212		14,875	27
28	Roofing			1991	10,852		20			10,852	28
29	Remodling Nurses Station			1991	153,267	7,916	20	7,916		98,659	29
30	Remodling Adm Bldg			1991	2,982		20			2,982	30
31	Walk in Cooler remodling			1991	44,095	2,205	20	2,205		25,811	31
32	Remodling kitchen			1991	31,445	1,572	10	1,572		19,650	32
33	Roofing			1992	12,170	1,217	15	1,217		11,505	33
34	Plumbing heating			1993	30,813	2,054	15	2,054		21,567	34
35	Painting decorataive tile			1992	14,977		10			14,977	35
36	Alarm system			1994	10,837	817	10	817		7,762	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Rose-Angela Hall

0033761

Report Period Beginning:

07/01/02

Ending:

06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Emergency lights snow melt cables, roofing	1995	\$ 65,535	\$ 3,893	10	\$ 3,893	\$	\$ 62,829		37
38	Handicap Bath, Whirlpool	1996	19,365	1,291	15	1,291		9,521		38
39	Painting, Patching, Decorating	1996	37,184	2,259	5	2,259		37,184		39
40	New Boiler	1996	32,273	1,614	20	1,614		11,971		40
41	Install Bath	1996	4,208	281	15	281		2,107		41
42	Repair glass, foofing	1996	2,996		15-Jan			2,996		42
43	Tuckpointing, roof repair	1997	6,428	642	10	642		4,173		43
44	Elctrical re a/c	1997	2,460	164	15	164		1,148		44
45	Window replacement a/c installation	1997	23,947	1,198	20	1,198		7,787		45
46	Painting, wall covering	1997	1,462		5			1,462		46
47	Architectural re windows, remodeling	1998	930	92	10	92		506		47
48	Elevator door	1998	1,200	80	15	80		440		48
49	New roof adm bldg	1998	13,968	698	20	698		3,839		49
50	Painting decorating adm bldg	1998	950	95	5	95		950		50
51	Guanelia Hall boiler	1998	14,758	738	20	738		4,059		51
52	New doors, stops, exits	1998	15,989	1,066	15	1,066		5,863		52
53	Painting, decorating	1998	25,548	2,553	5	2,553		25,548		53
54	Handrails	1998	6,132	408	15	408		2,244		54
55	New boiler, ht coils d#1	1998	53,531	2,676	20	2,676		14,774		55
56	Painting decorating Dorms	1999	18,294	3,659	5	3,659		16,465		56
57	Handicap handrails installed	1999	14,174	945	15	945		4,252		57
58	Install walk-in kitchen freezer	1999	17,409	1,161	15	1,161		5,225		58
59	Reconfigure office add handicap ramp&washroom	1999	54,060	2,703	20	2,703		12,164		59
60	Replace broken sewer & sidewalks	1999	17,168	859	20	859		3,865		60
61	New wallcovering and decorating G. hall	1999	23,831	2,383	10	2,383		10,723		61
62	Installation of fire pump	1999	8,300	415	20	415		1,868		62
63	Pipe in new heads re fire system	1999	2,060	137	15	137		617		63
64	Chapel roof repair & piping	1999	2,939	294	10	294		1,305		64
65	Carpeting Chapel	2000	1,511	302	5	302		649		65
66	Painting, wall covering re hallways	2000	1,742	174	10	174		609		66
67	New heaters hallways	2000	656	44	15	44		176		67
68	Remodel kitchen ramp	2000	35,464	1,773	20	1,773		7,076		68
69	Pavement repairs & replace	2000	10,527	526	20	526		1,839		69
70	TOTAL (lines 4 thru 69)		\$ 4,354,472	\$ 109,384		\$ 109,384	\$	\$ 3,157,264		70

**Improvement type must be detailed in order for the cost report to be considered complete.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,354,472	\$ 109,384		\$ 109,384		\$ 3,157,264	1
2	Install water supplt valves	2000	21,820	1,091	20	1,091		3,818	2
3	Windows replaced in dorms	2000	85,550	4,278	20	4,278		14,973	3
4	Roof repair - dorms	2000	13,520	1,352	10	1,352		4,732	4
5	Replace kitchen windows	2000	10,553	528	20	528		2,112	5
6	Brickwork, concrete re damaged walls	2000	8,885	444	20	444		1,354	6
7	New freezer to cooler	2000	63,982	3,199	20	3,199		11,212	7
8	Electric HVAC re freezer	2000	13,022	651	20	651		2,279	8
9	New water line piping	2000	11,006	550	20	550		1,925	9
10	Electric outlets emergency lights	2000	6,858	457	15	457		1,599	10
11	Asphalt paving lot	2001	5,141	1,028	5	1,028		2,328	11
12	Fire alarm system	2001	6,938	694	10	694		1,735	12
13	G. Hall decorating hallways	2001	5,540	1,108	5	1,108		2,770	13
14	Remove asbestos tile/replace	2001	5,192	519	10	519		1,299	14
15	Firewall doors framing	2001	22,631	1,508	15	1,508		3,770	15
16	New hot water tanks repiping	2001	24,801	1,654	15	1,654		4,168	16
17	Shower door, replace drain	2001	11,732	782	15	782		1,956	17
18	Outdoor pavilion, gazebos	2001	41,095	2,740	15	2,740		6,849	18
19	Balcony roof repair	2002	5,803	1,160	5	1,160		1,467	19
20	Fire alarm system	2002	4,496	450	10	450		675	20
21	Plumbing work	2002	42,173	4,217	10	4,217		6,325	21
22	Sidewalk replacement	2002	23,012	1,534	15	1,534		2,301	22
23	Electric re HVAC	2002	15,700	1,046	15	1,046		1,569	23
24	Tuckpointing	2002	11,585	1,158	10	1,158		1,737	24
25	Doors re Chapel	2003	1,642	82	10	82		82	25
26	Plumbing-Water tanks sm basin	2003	16,551	828	10	828		828	26
27	roof curbs	2003	12,430	414	15	414		414	27
28	Elec wiring&smoke dedtect	2003	5,327	271	10	271		271	28
29	Insolate pipes, door	2003	4,378	219	10	219		219	29
30	Windowa, tuckpointing, Nepco	2003	25,922	1,296	10	1,296		1,296	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,881,757	\$ 144,642		\$ 144,642		\$ 3,243,327	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 365,323	\$ 45,287	\$ 45,287	\$		\$ 395,375	71
72	Current Year Purchases	21,143	2,114	2,114			2,114	72
73	Fully Depreciated Assets	138,169					138,169	73
74								74
75	TOTALS	\$ 524,635	\$ 47,401	\$ 47,401	\$		\$ 535,658	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	Windstar 2002	2003	\$ 14,192	\$ 3,149	\$ 3,149	\$	4	\$ 3,149	76
77										77
78										78
79										79
80	TOTALS			\$ 14,192	\$ 3,149	\$ 3,149	\$		\$ 3,149	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,496,059	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 195,192	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 195,192	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,782,134	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ _____

13. /2005 \$ _____

14. /2006 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>80</u>
		HOURS PER AIDE <u>40</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		430		430
3	Classroom Wages (a)		2,580		2,580
4	Clinical Wages (b)		5,162		5,162
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 8,172	\$	\$ 8,172
10	SUM OF line 9, col. 1 and 2 (e)	\$ 8,172			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	7

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	1,022,033	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	233,105	471,127	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		51,997	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	12,124	12,124	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 245,229	\$ 1,557,281	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,012,004	3,694,315	15
16	Equipment, at Historical Cost	538,827	1,256,032	16
17	Accumulated Depreciation (book methods)	(822,847)	(2,620,246)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 727,984	\$ 2,330,101	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 973,213	\$ 3,887,382	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 21,327	\$ 181,604	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	95,547	131,703	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,926	5,879	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 119,800	\$ 319,186	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 119,800	\$ 319,186	46
47	TOTAL EQUITY(page 18, line 24)	\$ 853,413	\$ 3,568,196	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 973,213	\$ 3,887,382	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,030,627	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,030,627	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(177,214)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (177,214)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 853,413	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	3
	B. Ancillary Revenue		
4	Day Care	3,417,865	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,417,865	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	7,742	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 7,742	23
	D. Non-Operating Revenue		
24	Contributions	9,407	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,407	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,435,014	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	650,597	31
32	Health Care	1,807,102	32
33	General Administration	749,816	33
	B. Capital Expense		
34	Ownership	195,192	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	209,521	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,612,228	40
41	Income before Income Taxes (line 30 minus line 40)**	(177,214)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (177,214)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? n/a If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Rose-Angela Hall# 0033761Report Period Beginning: 07/01/02Ending: 06/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		1,820	\$ 39,860	\$ 21.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses		6,151	137,038	22.28	3
4	Licensed Practical Nurses		7,251	161,463	22.27	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director		2,195	51,134	23.30	9
10	Activity Assistants		188	989	5.26	10
11	Social Service Workers		133	5,974	44.92	11
12	Dietician					12
13	Food Service Supervisor		2,080	42,824	20.59	13
14	Head Cook		233	4,762	20.44	14
15	Cook Helpers/Assistants		11,402	102,183	8.96	15
16	Dishwashers					16
17	Maintenance Workers		5,101	88,291	17.31	17
18	Housekeepers		6,533	56,232	8.61	18
19	Laundry		2,067	15,354	7.43	19
20	Administrator		2,600	71,370	27.45	20
21	Assistant Administrator		1,414	28,284	20.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical		10,293	138,757	13.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director		250	25,631	102.52	27
28	Qualified MR Prof. (QMRP)		14,630	243,837	16.67	28
29	Resident Services Coordinator		14,560	252,070	17.31	29
30	Habilitation Aides (DD Homes)		83,180	773,401	9.30	30
31	Medical Records		2,080	30,509	14.67	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)		174,161	\$ 2,269,963 *	\$ 13.03	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	130	\$ 4,620	Lin 1 C3	35
36	Medical Director				36
37	Medical Records Consultant	37	1,472	Lin 10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	577	30,854	Line 10aC3	40
41	Occupational Therapy Consultant	115	6,139	Line 10aC3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Dentist</u>	n/a	4,065	Lin 10 C3	46
47	<u>Psychologist-Psychiatrist</u>	21	2,626	Line 10 C3	47
48	<u>Food Service Professional MgmtFee</u>	n/a	17,725	Lin 1 C3	48
49	TOTAL (lines 35 - 48)	880	\$ 67,501		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 610	Lin 10C3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$ 610		53

Facility Name & ID Number **Rose-Angela Hall**# **0033761**Report Period Beginning: **07/01/02**Ending: **06/30/03****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership	Amount	D. Employee Benefits and Payroll Taxes			Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function	%			Description				Description		
Sr. Janet Kosman	Administrator		\$	71,370	Workers' Compensation Insurance	\$	46,190	IDPH License Fee	\$	200	
Darlene Zadnowski	Asst.Administrator			28,284	Unemployment Compensation Insurance		15,895	Advertising: Employee Recruitment		5,579	
					FICA Taxes		138,991	Health Care Worker Background Check		408	
					Employee Health Insurance		89,603	(Indicate # of checks performed <u>34</u>)			
					Employee Meals						
					Illinois Municipal Retirement Fund (IMRF)*						
					Pension		57,906				
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$	99,654						
B. Administrative - Other					TOTAL (agree to Schedule V, line 22, col.8)			\$	348,585		
Description				Amount							
				\$							
TOTAL (agree to Schedule V, line 17, col. 3)				\$							
(Attach a copy of any management service agreement)											
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount			
Deloitte & Touche LLP	Audit		\$ 36,783				Out-of-State Travel	\$			
							In-State Travel				
							Seminar Expense				
							IAP-IABA Activities-Consistency	415			
							IL St-OCC-AAMR-Mental Health	610			
							Council Rehab.Crisis Prev.Productivity	699			
							Entertainment Expense	()			
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL			\$			
(If total legal fees exceed \$2500 attach copy of invoices.)				\$	36,783	(agree to Sch. V, line 24, col. 8)			\$	1,724	

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. NO
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,260 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 209,521
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 15%
- d. Have vehicle usage logs been maintained? YES
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: Deloitte & Touche LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? n/a
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID Number RoseAngela Hall #0033761
Report Period: July 1, 2002-June 30, 2003

SCHEDULE VII -A- PAGE 24

List of Board Members during period July 1, 2002-June 30, 2003

NAME	OFFICE
Sr. Patricia McCafferty	President
Sr. Rita Butler (1)	Secretary
Sr. Antoinette Palmisano	Treasurer
Sr. Janet Kosman	Director
Sr. Noreen Franzina	Director

Provide services to Rose Angela Hall-

(1) Sr. Rita Butler approves invoices for payment and oversees maintenance of buildings.

The facility pays rent to the religious order, The Daughters of St. Mary of Providence for the use of the building and grounds.

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SCHEDULE VIII Allocation of Indirect Costs SEE ATTACHED WORKSHEETS